Application to Maintain Records at a Location Other than the Pharmacy

Pharmacy Information

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>ACP Licence Number</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>Postal Code</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
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<tbody>
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Storage Facility Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
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Provide the names and contact information for any persons who own, lease or control or are involved in any manner in storing the records at the above facility:

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Title</th>
<th>Phone Number</th>
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If the storage location is not a formal storage facility provide a description of where the records will be housed.

How will the records be secured?

Other than the licensee who will have access to the stored records?

- [ ] nobody
- [ ] pharmacy technicians
- [ ] staff pharmacists
- [ ] pharmacy employees
- [ ] pharmacy owners
- [ ] cleaners
- [ ] front store managers
- [ ] front store staff
- [ ] other _______________________

Types of Records to be stored off site

- [ ] electronic records
- [ ] computer server
- [ ] prescription hard copy
- [ ] current records
- [ ] archived records
- [ ] other _______________________

Licensee Information

I, _____________________________________________________________

licensee full name                                      ACP Registration Number

hereby acknowledge that:

- [ ] I will maintain the care and control of the records stored at the above listed facility
- [ ] I will restrict and control access to the records stored at the above listed facility
- [ ] I will ensure the requirements of the Standards for Operating Licensed Pharmacies are met in regards to the above records

By completing this application form I hereby make a request to maintain records at a location other than the pharmacy in accordance with Sections 12(4) and 12(5) of the Pharmacy and Drug Regulation and I declare that all the information on this application and any information supplied in support of this application is true to the best of my knowledge.

_________________________________________________________  _____________________________
Licensee Signature                                           Date
Application to Maintain Records at a Location Other than the Pharmacy

Proprietor’s Representative Information

I, __________________________________________________________________________

Proprietor’s representative full name ACP Registration Number (if applicable)

hereby acknowledge that:

☐ I have taken reasonable steps to ensure that records are maintained in accordance with the legislation.
☐ I will provide any assistance required by the pharmacist, responsible for the patient records, in respect of carrying out their duties.
☐ I will provide the pharmacist, responsible for the patient records, any records that are in the possession or under the control of the proprietor, if those records are requested by the pharmacist.

By completing this application form I hereby make a request to maintain records at a location other than the pharmacy in accordance with Sections 12(5) and 12(6) of the Pharmacy and Drug Regulation and I declare that all the information on this application and any information supplied in support of this application is true to the best of my knowledge.

Proprietor’s Representative Signature _____________________________ Date _____________________________